Joint Meeting of Health Planning Council and Health Planning Advisory Committee
July 23, 2014
250 Washington St.
Public Health Council Room, 2nd fl.
Boston, MA
3:30 p.m. - 5:00 p.m.

Health Planning Council Members Present:
Cheryl Bartlett, Commissioner, Department of Public Health (DPH); Lori Cavanaugh representing Áron Boros, Executive Director, Center for Health Information and Analysis (CHIA); Thomas Concannon, Rand Corporation; Kathy Sanders representing Marcia Fowler, Commissioner, Department of Mental Health (DMH); Ann Hartstein, Secretary, Executive Office of Elder Affairs (EOEA); John Polanowicz, Chairperson, Secretary, Executive Office of Health and Human Services (EOHHS); David Seltz, Executive Director, Health Policy Commission (HPC), and Kristin Thorn, Director, Medicaid Program.

Health Planning Advisory Committee Members Present:
Dana Bushell, Program Manager, Massachusetts Group Insurance Commission; Dr. Alice Coombs, Milton and South Shore Hospitals; Anuj Goel, Vice President, Legal and Regulatory Affairs, Mass. Hospital Association; Michael Hirsh, Acting Commissioner of Public Health, City of Worcester; Dr. Myechia Minter-Jordan, President and CEO, The Dimock Center; Mary Ann O'Connor, President and CEO of the VNA Care Network and Hospice; Sarah Chiaramida representing Lora Pellegrini, President and CEO, Massachusetts Association of Health Plans; Brian Rosman, Research Director, Health Care for All; James Willmuth, Senior Policy Analyst, SEIU 1199.

Secretary Polanowicz called the meeting to order at 3:34 p.m. He asked if there were any comments on the Minutes of the May 20, 2014 meeting. There being none, he asked for a motion to approve the Minutes. After a motion made and seconded, the Minutes were approved unanimously.

Secretary Polanowicz then turned the meeting over to DPH Associate Commissioner Madeleine Biondolillo for the presentation. Dr. Biondolillo reviewed the agenda for the meeting. She reviewed what has been completed to date as well as the research questions that frame the analysis.

Regarding the need/prevalence data for mental health conditions, Dr. Biondolillo noted that need is defined in the context of prevalence, and reviewed the three areas of mental illness described on slide 8: Any Mental Illness, Serious Mental Illness, and Minor and Serious Emotional and Behavioral Difficulties.

Based on SAMHSA national survey data, half of the people with any mental illness did not get treatment but did not report an unmet need. As indicated on slide 11, 89% of the people with a substance use disorder did not receive treatment and 95% of those people did not feel the need for treatment. A small percentage of the people who did not receive treatment either tried and failed to receive treatment or did not try to receive treatment. The information raises questions

about awareness and access. Dr. Minter-Jordan asked, "What are the resources that people are not getting? Is the problem due to lack of awareness?"

The health planning statute directs the Council/Advisory Committee to consider what might happen over the next five years. As shown in slide 12, the estimated population increase between 2014 and 2020 is 1.8% statewide, with little regional variation. The increase will have a very small impact on the capacity projections. Ethnicity and race data are not readily available for the Health Policy Commission regions. Staff will work towards obtaining that data in the future.

Dr. Biondolillo reviewed the service definitions for mental health and substance abuse services that were presented at previous meetings. She again thanked the Department of Mental Health and the DPH Bureau of Substance Abuse Services for their efforts.

Dr. Biondolillo then presented the inpatient mental health inventory data. There are 67 acute hospitals or psychiatric units in Massachusetts, including 15 free-standing acute psychiatric hospitals, 50 psychiatric units in general hospitals, and two psychiatric units in state mental health facilities. In 2014, there are 2431 inpatient beds that receive clients from across the state. For the 6.6 million Massachusetts residents, the ratio of beds to population is 37 beds per 100,000 population. From 2010 to 2014 bed capacity has grown 5% among the free-standing hospitals and 2% among all hospitals. There has been no growth for general acute hospital psychiatric beds that may provide care for more complex, medically involved cases.

Similar data were presented for substance abuse inpatient and other acute services. There are 1399 beds that receive clients from a statewide population of 5.6 million residents 13 years and older, for a ratio of beds to population of 25 beds per 100,000.

Dr. Biondolillo presented maps for the mental health inpatient beds per 100,000 population by region. She noted that the team hopes to add interactivity to the maps before the next meeting. The maps included all acute care hospital locations, regardless of whether they have psychiatric beds. Dr. Concannon suggested that the staff bin or group the rates of beds per 100,000 and grade the color. He pointed to the example of Western and Northeast regions that have similar rates at 31.4 and 32.8, respectively. Similar maps were presented for substance abuse inpatient and other acute services beds for the population 13 years of age and older. The Central Massachusetts and Cape Cod regions have the highest concentration of beds, while the MetroWest region has the lowest. Dr. Biondolillo noted that the inventory continues to evolve. She added that a graphic will be added in the place of the current bullets on slide 21: Inpatient Capacity: MH and SA, which includes the American College of Emergency Physician report card benchmarks for other states.

Dr. Biondolillo then presented utilization data, including information on the sources and methods on slide 23. There are five main sources: MassHealth; Medicare; Commercial All Payer Claims Data; DMH and BSAS. De-identified data from 2010-2012 were analyzed and the sample was limited to claims with a primary diagnosis within the range of ICD9-CM Diagnosis Codes presented.

Dr. Biondolillo noted the limitations of the data, including for example:

- The analysis of commercial care focused on the top 17 health plans (by number of behavioral health clients), capturing 92% of APCD's 2012 commercial enrollment.
- Medicare data are based on a random 5% sample of FFS utilization.
- MassHealth Data includes data for members for whom MassHealth may be a partial or third party payor.
- The ICD9-CM diagnosis codes that were used did not include E-codes (i.e., suicides, suicide attempts, injuries and overdoses) potentially understating overall level of substance use disorder-related utilization.
- Because claims were selected based on diagnosis codes, changes in coding practices could be a factor in explaining a change in utilization.
- Differences across payors in how fields are populated on claims could result in inaccuracies in the reported utilization.

Dr. Biondolillo solicited feedback on the slides that followed regarding data sources and definitions and enrollment by payor groups. She particularly called attention to the 2012 total enrollments for Medicare, MassHealth, and APCD on slide 28.

Dr. Concannon asked on slide 29 if 'utilization' is the percent enrolled with a payor who use the service. The answer was yes. Mr. Seltz commented on the information being for 2012 only. Dr. Biondolillo responded that 2012 was the most recent complete dataset available. The data provide a baseline. The group would be interested in future trend data.

Mr. Rosman asked if the data could be broken out for outpatient by service, e.g., methadone, case management, etc. Ms. Jingying Yang of the Health Policy Commission noted that commercial claims have undercounting because there is no analysis of pharmacy claims.

On slide 29, it was noted that a correction is necessary in the color coding of the payors. For consistency with other slides, MassHealth should be blue, commercial should be green.

Dr. Sanders commented that she was surprised at the high rate of utilizers/1000 enrollees for the Medicare 5%. Ms. Yang suggested that the Medicare data on slide 30, currently showing that Medicare FFS had the highest rates of utilizers/1000 enrollees for inpatient care and emergency room visits for both mental health and substance abuse, could be broken out by under age 65 and 65 and over.

The next few slides present trend data for inpatient and acute treatment services by payor for age, gender and geography. Utilization of MH and SA inpatient days decreased over the three-year period, but the magnitude varied across payors. Utilization of emergency room visits appeared to increase among Medicare enrollees. Dr. Biondolillo highlighted, on slide 33, the utilization for MH services for the 0-25 year old age group.

Regarding the regional variation presented on slide 35, Dr. Biondolillo noted that outpatient data will be more challenging to analyze and present because DMH and BSAS do not collect data by these regions. In addition the data are collected by zip code of the patient/client, not the provider.

Dr. Concannon asked about an apparent pattern of a higher relative share of users in the Medicaid payor group for inpatient services and crisis service use for the Cape and Islands compared to the rest of the regions. He asked if this suggests an acuity issue in the Cape and Islands region. Is it a poverty issue? It was noted that there are fewer resources on the Cape as well as a seasonal burden.

Slide 37 summarized some of the issues around the utilization data collection and reporting to bear in mind as the Council reviews these data. The Council and Advisory Committee were reminded that these data are laying the health planning groundwork.

On slide 38, Mr. Willmuth noted for Flex services the relatively large annual average percentage increase in the number of clients served, and asked why that occurred. Brooke Doyle, DMH Assistant Commissioner for Mental Health Services, responded that Flex services are a pool of resources separate and distinct from anything Medicaid might be providing. The increase represents changing philosophies in systems of care. Dr. Sanders added that a lot of Flex services keep and support families in homes.

Dr. Coombs asked if staff is able to tease out which changes are due to Managed Care Programs (ACA). Mr. Richard Dougherty responded that slides beginning with slide 38 reflect only state agencies; the previous slides present inpatient and emergency room services by payor but do not further segment members. Of note, most ACA related changes took effect in 2014, and the data shown predates those changes.

Mr. Rosman asked if private payors cover fewer behavioral health services, whether clients are then showing up in emergency rooms. Dr. Sanders responded that she didn't think so because many mental health services are paid by insurance. Ms. Doyle added that DMH services are for a very specific subset of patients.

Dr. Concannon commented that in a previous slide only 32 mental health acute beds out of 2400 were operated by the state. He asked why have them at all if there are only 32; what special role do they serve? Ms. Doyle responded that those beds provide acute services in the southeast portion of the state at Corrigan and Pocasset Mental Health Centers, and are part of a network of services. Secretary Polanowicz added that they were 'holdover beds' and that there was pressure not to close beds in that region. The concern raised was whether need was being met with that small number. Ms. Doyle responded that they are not the only resource for patients. Secretary Polanowicz added that those beds could have been included with the free-standing beds.

Dr. Biondolillo welcomed feedback on slide 40: acute bed capacity for mental health and substance abuse. Mr. Rosman asked if occupancy rates are the best indicator considering all the limitations. Dr. Biondolillo responded that it is necessary to look at occupancy rates, but they are not the only indicator. Secretary Polanowicz expressed surprise at the 28% "other payors/unoccupied", particularly in light of the numbers of patients who are boarding in emergency departments while waiting for a psychiatric bed placement. He summarized that we know where the resources are, what the demand curves look like, and have perceptions of unmet need. He asked if there are other proxies for occupancy rate, without deep data mining, to

continue to try to evolve. Mr. Dougherty suggested they could sample what occupancy rates are for psychiatric beds from other states.

Dr. Sanders noted that Mass. Behavioral Health Partnership's inpatient census tracking system tracks all general hospital psychiatric units and they are all generally 100 percent occupied. Dr. Coombs added that the free-standing psychiatric hospitals' average occupancy rate of 84% does not surprise her. She noted that staffing with beds can fluctuate and the occupancy rate does not dovetail with that. She added that expansion has to do with more than the number of beds.

Dr. Biondolillo commented that from the perspective of health planning there are limitations. Need is a complex issue. We have capacity with data limitations for inpatient and the emergency department. There are a lot of 'next steps'. Further analysis, not necessarily by the health planning team, could be done to analyze the capacity to provide services. She requested feedback.

Sarah Chiaramida suggested that stratification of different types of beds (pediatrics, geriatric, etc.) would be helpful, as well as indicating which hospitals have inpatient psychiatric beds. Dr. Biondolillo noted that prior presentations included the youth and geriatric beds and that next steps include showing which hospitals have inpatient psychiatric beds.

Secretary Polanowicz asked Anuj Goel about the incentives for providers to run at as full occupancy as possible. Mr. Goel agreed that the goal for providers is to keep as full as possible based on staffed beds.

In the Conclusions slides, it was suggested that staff try to drill down on the first bullet on slide 42, which states "inpatient MH capacity appears high relative to other states and showed a slight increase from 2010-2012, but measures of utilization suggests a decline."

Dr. Biondolillo noted that this work has produced a first-of-its-kind baseline for MH and SA service inventory, need and utilization across payors. It establishes a framework for the Determination of Need Program and other organizations to use.

Dr. Hirsh congratulated the team on all the work that had gone into developing this framework. He commented on his own work providing trauma care for children and the many meetings he is involved in trying to place patients. The number one reason he has difficulty in finding a bed is for patients who have tried to kill themselves and are badly injured. Rehabilitation facilities will not take the patients because of their psychiatric issues and there are no psychiatric beds available. As a result, the patients may remain in the emergency department ("boarding") for several weeks. He commented on the disconnect between his experience and the sense from the presentation that there appears to be capacity.

Secretary Polanowicz commented that the group should strike from their minds the slide that showed capacity. Sixteen percent of beds are not available and waiting for patients.

Dr. Biondolillo added that the data are based on licensed beds, but even with staffed beds there are different levels of staffing. Certain needs can be challenging from a staffing perspective. She

asked if this is a health planning issue. Analyzing which facilities take patients – when, why, and how – is taking planning to another level.

Dr. Minter-Jordan suggested highlighting the next level of work. If there is capacity and still demand, strike the slide. What are the circumstances that require patient advocacy in order to achieve bed placement?

Secretary Polanowicz commented that data have been presented in a number of aggregate ways. He asked that the Council and Advisory Committee members take time to review the data and then asked for their help in defining a strong set of conclusions. He asked that they think about the framework and let it guide recommendations.

Dr. Concannon made two suggestions to get at the final numbers:

1) look at other states' health plans to see what number reflects full capacity, a "theoretical max"; and
2) qualitative follow-up; work through syntheses of these numbers.

Dr. Biondolillo asked if focus groups or interviews would be helpful. Alternatively, information could be culled from the surveys conducted earlier this year.

Mr. Rosman asked if another agency were to do a microanalysis, could these data inform that.

Secretary Polanowicz responded that through this effort we have tried to align regional analysis with the Health Policy Commission. The regions may not align with the primary and secondary service areas of a particular health system.

Mr. Seltz commented on a transaction specific review conducted by the Health Policy Commission. The Commission looked at occupancy rates as a bellwether for medical/surgical versus behavioral health beds. Their conclusion was that there is not excess capacity, but lower occupancy on medical/surgical beds. He added that the whole system is changing and we need to be able to track it statewide.

Dr. Biondolillo concluded the meeting by announcing that there would be another meeting in mid-September. The next domain to be covered will be percutaneous coronary intervention (PCI). She added that issue briefs had been handed out for evaluation and comment.

The meeting adjourned at 5:00 p.m.